New Jersey Department of Health and Senior Services
Division of Aging and Community Services
Office of Long Term Care Options

REQUEST FOR BILLING ASSISTANCE

Long Term Care Field Office _____

Telephone Number ( ) _____ Fax Number ( ) _____

PLEASE PRINT

Facility Name _____ Facility Provider No. _____

Name of Facility Contact Person _____

Telephone Number ( ) _____ Fax Number ( ) _____

Name of Client _____
(Last) *(First)* *(MI)*

DOB _____ Sex ☐ Male ☐ Female

Medicaid No. _____ Social Security No. _____

Date of PAS _____ Date of Admission _____

Denied Dates of Service _____

Edit Code _____

Anticipated Amount of Denied Reimbursement (optional) _____

Rejection Narrative and Additional Information/Comments:

FOR LONG TERM CARE FIELD OFFICE USE:

Date Corrected _____ Corrections Could Not Be Made _____

Comments:

Please contact _____ at the above telephone number, if you have questions.

LTC-19
MAR 03